EMS-251 (7/12)

Department of Community Health
Emergency Medical Services Section
P.O. Box 30437
Lansing, MI 48909
(517) 241-0179

VERIFICATION OF MILITARY EDUCATION PROGRAM

Authority: Public Act 368 of 1978, as amended.

PART I – To be completed by the applicant and forwarded to the appropriate Military Branch for completion. If you do not meet the education requirements for your level as outlined in PART II of this form, you are not eligible for licensure in Michigan. You will be required to complete a Michigan Initial Education Course to become eligible.

First Name	Middle Name	Last Name	
Social Security Number	Date of Birth	Daytime Telephone Number	
Street Address	City	State	Zip Code
All Previous Names and/or Birth Names Used (if applicable)	Military Branch		Course Complete Date

PART II – To be completed by the appropriate Military Branch

The applicant named above has applied for EMS licensure in Michigan and has indicated they have completed a Military EMS Education Course within the last year. Please complete Part II of this form to verify course completion and return it to the address shown above. (**MUST BE RECEIVED WITH ORIGINAL SIGNATURE; FAXED COPIES ARE NOT ACCEPTED)**

Name of Military Education Facility		Telephone Number	
Street Address	City	State	Zip Code
Level of Education ☐ Medical First Responder ☐ Basic EMT ☐ Specialist AEMT ☐ Paramedic			Course Completion Date

If applying for **MFR,** did the applicant's training include Spinal Immobilization AND Epi-Pen?
☐ No ☐ Yes

If applying for **EMT**, did the applicant's training include Supraglottic Airway (e.g., combitube, king), Epi-Pen, AND Albuterol?
☐ No ☐ Yes

If applying for **Specialist (AEMT) or Paramedic**, did the applicant's training meet the National Education Standard Guidelines?
☐ No ☐ Yes

CERTIFICATION

I hereby certify that, to the best of my knowledge_____ completed all requirements for a United States Military Course for
Name of Applicant

a_____ on _____.
Level of Education Course Completion Date

_____ _____
Signature Date

_____ _____
Type or Print Name Title

_____ _____
Name of Military Branch Phone Number

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs know to this agency